TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Elite Healthcare Fort Worth

Respondent Name
City of Fort Worth

MFDR Tracking Number
M4-16-0487-01

Carrier's Austin Representative
Box Number 04

MFDR Date Received
October 23, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier is incorrect on this denial for this patient. On this date of service, patient was seen by Dr. Lopez which is the patient's treating provider at our facility. Dr. Lopez **DISCUSSED** with the patient **DD report** from **another physician.**"

Amount in Dispute: $113.86

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Dr Lopez should be reimbursed for the office visit of 99213."

Response Submitted by: WellComp Managed Care Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 10, 2015	Evaluation & Management, established patient (99213)	$113.86	$113.86

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the procedures for submitting a medical bill.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - B20 – Service partially/fully furnished by another provider.
   - Note: Per Rule 133.20(e)(2) a medical bill must be submitted in the name of the licensed HCP that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care.

- 193 – Original payment decision maintained

Issues

1. Is the insurance carrier's reason for denial of payment supported?
2. What is the maximum allowable reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code B20 – "Srvc partially/fully furnished by another provider." 28 Texas Administrative Code §133.20(e) requires that "A medical bill must be submitted: … (2) in the name of the licensed health care provider that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care."

   Review of the submitted documentation supports that the medical bill was submitted in the name of the licensed health care provider that provided the health care, in accordance with 28 Texas Administrative Code §133.20(e). In their position statement, the insurance carrier did not maintain their denial, stating that, "Dr Lopez should be reimbursed for the office visit of 99213." The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code §134.203 (c) states,

   > To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   > (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83…
   > (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year…

   The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. The Division conversion factor for 2015 is $56.20.

   For CPT code 99213 on March 10, 2015, the relative value (RVU) for work of 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1.005 is 0.974850. The practice expense (PE) RVU of 1.01 multiplied by the PE GPCI of 0.995 is 1.004950. The malpractice (MP) RVU of 0.06 multiplied by the MP GPCI of 0.772 is 0.046320. The sum of 2.026120 is multiplied by the Division conversion factor of $56.20 for a MAR of $113.87.

3. The total MAR for the disputed service is $113.87. The requestor is seeking reimbursement of $113.86. The insurance carrier paid $0.00. A reimbursement of $113.86 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $113.86. This decision is based on the information available at the time of review.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $113.86 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	December 30, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.